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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

C. GENERAL REIMBURSEMENT POLICIES (cont.)

3. DRG High-Cost Outlier Payments

High-cost outliers are cases with extraordinarily high costs when compared to other cases in the same DRG. The reimbursement system includes an outlier payment for these cases. To qualify as a DRG high-cost outlier, the allowed charges for the case must exceed a threshold of three times the applicable DRG payment and $33,000.

Reimbursement for outlier cases other than cases in children's hospitals (Children's Hospital and Medical Center, Mary Bridge Children's Hospital), and psychiatric DRGs, is the applicable DRG payment amount plus 75 percent of the hospital's RCC ratio applied to the allowed charges exceeding the outlier threshold.

Reimbursement for DRG psychiatric (DRGs 424-432) outliers is at the DRG rate plus 100 percent of the hospital RCC ratio applied to the allowed charges exceeding the outlier threshold. Reimbursement for outlier cases at the state's two children's hospitals is the applicable DRG payment amount plus 85 percent of the hospital's RCC ratio applied to the allowed charges exceeding the outlier threshold.

4. DRG Low Cost Outlier Payments

Low cost outliers are cases with extraordinarily low costs when compared to other cases in the same DRG. To qualify as a DRG low cost outlier, the allowed charges for the case must be equal to or less than the greater of 10 percent of the applicable DRG payment or $450. Reimbursement for these cases is the case's allowed charges multiplied by the hospital's RCC ratio.

5. DRG Long-Stay Day Outlier Payments

Day Outlier payments are included only for long-stay clients, under the age of six, in disproportionate share hospitals and for children under age one in any hospital. (See C.15 Day Outlier payments).

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

C. GENERAL REIMBURSEMENT POLICIES (cont.)

6. Non DRG payment method payments

Hospitals and services exempt from the DRG payment method are reimbursed under the RCC method, "full cost" method, CAH method, etc. For RCC and "full cost" payments, the basic payment is established by multiplying the hospital's assigned RCC ratio (not to exceed 100 percent) by the allowed charges for medically necessary services. Recipient responsibility (spend-down) and third-party liability, as identified on the billing invoice or otherwise by DSHS, is deducted from the allowed amount (basic payment) to determine the actual payment for that admission.

7. DRG Exempt Hospitals

The following hospitals are exempt from the DRG payment method for Medicaid.

a. Peer Group A Hospitals

As defined in Section D.2.

b. Psychiatric Hospitals

Designated psychiatric facilities, state psychiatric hospitals, designated distinct part pediatric psychiatric units, and Medicare-certified distinct part psychiatric units in acute care hospitals are this type of facility. This currently includes, but is not limited to, Fairfax Hospital, Lourdes Counseling Center, West Seattle Psychiatric Hospital, Puget Sound Behavioral Health, the psychiatric unit at Children's Hospital & Medical Center, and all other Medicare-certified and State-approved distinct part psychiatric units doing business with the State of Washington.

c. Rehabilitation Units

Rehabilitation services provided in specifically identified rehabilitation hospitals and designated rehabilitation units of general hospitals. The criteria used to identify exempt hospitals and units are the same as those employed by the Medicare program to identify designated distinct part rehabilitation units.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

C. GENERAL REIMBURSEMENT POLICIES (cont.)

7. DRG Exempt Hospitals (cont.)

In addition, services for clients in the MAA Physical Medicine and Rehabilitation program (PM&R), and who are not placed in a designated rehabilitation hospital or unit, are excluded from DRG payment methods. Prior authorization is required for PM&R services and placement into the rehabilitation unit.

d. Critical Access Hospital (CAHs)

Department-approved and Medicare designated CAHs receive Medicaid prospective payment based on Departmental Weighted Cost-to-Charge (DWCC). Post-period cost settlement is then performed.

e. Managed Health Care

Payments for clients who receive inpatient care through managed health care programs. If a client is not a member of the plan, reimbursement for admissions to managed health care program hospital will be determined in accordance with the applicable payment methods for contract or non-contract hospitals described in Section D, Section E and/or Section F.

f. Out-of-State Hospitals

Out-of-state hospitals are those facilities located outside of Washington and outside designated border areas as described in Section D. For medically necessary treatment of emergencies that occur while a client is out-of-state, these hospitals are exempt from DRG payment methods, and are paid an RCC ratio based on the weighted average of RCC ratios for in-state hospitals. For DSHS referrals to out-of-state providers after MAA's Medical Director or designee approved an Exception to Rule for the care:

(1) In absence of a contract, DSHS pays the rate mentioned above.

(2) When DSHS is successful negotiating a contract, out-of-state hospitals are paid using a negotiated contract rate. DSHS first negotiates for the rate mentioned above, then for the other state's Medicaid or Medicare rate, and finally for the best rate possible beyond the other tiers.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

C. GENERAL REIMBURSEMENT POLICIES (cont.)

7. DRG Exempt Hospitals (cont.)

g. Military Hospitals

Unless specific arrangements are made, Military hospitals are exempt from the DRG payment methods, and are reimbursed at their allowed charges.

h. Public Hospitals Located In The State of Washington

Beginning on July 1, 2005, for public hospitals located in the State of Washington that are owned by public hospital districts and are not department approved and DOH certified as CAH, the Harborview Medical Center, and the University of Washington Medical Center, Medicaid and GAUDSH covered services are paid by the "full cost" public hospital certified public expenditure (CPE) payment method. The new payment methodology incorporates the use of certified public expenditures at each hospital as the basis for receiving federal Medicaid funding.

8. DRG Exempt Services

a. Neonatal Services

DRGs 620 and 629 (normal newborns) are reimbursed by DRG payment under the DRG payment method, but not under "full cost", or cost settlement. DRGs 602-619, 621-624, 626-628, 630, 635, 637-641 neonatal services are exempt from the DRG payment methods, and are reimbursed under the RCC, "full cost", or cost settlement payment method.

b. AIDS-Related Services

AIDS-related inpatient services are exempt from DRG payment methods, and are reimbursed under the RCC method for those cases with a reported diagnosis of Acquired Immunodeficiency Syndrome (AIDS), AIDS-Related Complex (ARC), and other Human Immunodeficiency Virus (HIV) infections.

c. Long-Term Care Services

Long-term care services are exempt from DRG payment methods. These services are reimbursed based on the statewide average Medicaid nursing home rate, adjusted for special staff and resource requirements. Hospitals must request a long-term care designation on a case-by-case basis.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

C. GENERAL REIMBURSEMENT POLICIES (cont.)

8. DRG Exempt Services (cont.)

d. Bone Marrow and Other Major Organ Transplants

Services provided to clients receiving bone marrow transplants and other major organ transplants are exempt from the DRG payment method, and are reimbursed under the RCC method.

e. Chemically-Dependent Pregnant Women

Hospital-based intensive inpatient care for detoxification and medical stabilization provided to chemically-dependent pregnant women by a certified hospital are exempt from the DRG payment method, and are reimbursed under the RCC payment method.

f. Long-Term Acute Care Program Services

Long-Term Acute Care (LTAC) services, and other inpatient services provided by LTAC hospitals, are exempt from DRG payment methods. LTAC services covered under the LTAC rate are reimbursed using a fixed per diem rate. Other covered LTAC services are paid using the RCC rate. The fixed per diem rate was based on an evaluation of patient claims costs for this type of patient and is updated annually through a vendor rate_adjustment (VRA). Hospitals must request and receive a LTAC designation. Care is authorized and provided on a case-by-case basis.

g. Services Provided in DRGs that do not have a Medical Assistance Administration relative weight assigned.

Services provided in DRGs that do not have a Medical Assistance Administration relative weight assigned, that would otherwise be paid using the DRG payment method, are reimbursed using the RCC, "full cost", or cost settlement payment method unless a different payment method has been specified.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

C. GENERAL REIMBURSEMENT POLICIES (cont.)

8. DRG Exempt Services (cont.)

Trauma Center Services

Trauma Centers are designated by the State of Washington Department of Health (DOH) into five levels, based on level of services available. This includes Level I, the highest level of trauma care, through Level V, the most basic trauma care. Level of designation is determined by specified numbers of health care professionals trained in specific trauma care specialties, inventories of specific trauma care equipment, on-call and response time minimum standards, quality assurance and improvement programs, and commitment level of the facility to providing trauma related prevention, education, training, and research services to their respective communities.

Level I, II, and III trauma centers services will be reimbursed using an enhanced payment based on the trauma care fund established by the State of Washington in 1997 to improve the compensation to physicians and designated trauma facilities for care to Medicaid trauma patients. The payment is made through lump-sum supplemental payments made quarterly.

The payment each hospital receives is proportional to the percentage that the department pays in total to all Level I, II, and III trauma centers quarterly for fee-for-service trauma case claims. Each qualifying hospital's payment percentage is then applied to the department's total enhanced trauma supplemental funds available for the quarter to determine the hospital's proportional payment from the quarter's trauma supplemental. A fee-for-service case qualifies for trauma designation if care provided has an Injury Severity Score (ISS) of 13 or greater for adults, 9 or greater for pediatric patients (through age 14 only), and transferred trauma patients regardless of ISS.

Level IV and V trauma centers are given an enhanced payment outside of Medicaid by the State's Department of Health using only State funds.

h. Inpatient Pain Center Services

Services in MAA authorized inpatient pain centers are paid using a fixed per diem rate.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

C. GENERAL REIMBURSEMENT POLICIES (cont.)

9. Transfer Policy

For a hospital transferring a client to another acute care hospital, a per diem rate is paid for each medically necessary day. The per diem rate is determined by dividing the hospital's payment rate for the appropriate DRG by that DRG's average length of stay.

Except as indicated below, the payment to the transferring hospital will be the lesser of: the per diem rate multiplied by the number of medically necessary days at the hospital; or, the appropriate DRG payment.

If a client is transferred back to the original hospital and subsequently discharged, the original hospital is paid the full DRG payment. It is not paid an additional per diem as a transferring hospital. The intervening hospital is paid a per diem payment based on the method described above.

The hospital that ultimately discharges the client is reimbursed the full DRG payment; however, if a transfer case qualifies as a high or low cost outlier, the outlier payment methodology is applied.

10. Readmission Policy

Readmissions occurring within 7 days of discharge, to the same hospital that group to the same medical diagnostic category, will be reviewed to determine if the second admission was necessary or avoidable. If the second admission is determined to be unnecessary, reimbursement will be denied. If the admission was avoidable, the two admissions may be combined and a single DRG payment made. If two different DRG assignments are involved, reimbursement for the appropriate DRG will be based upon a utilization review of the case. All psychiatric inpatient admissions must be prior authorized and are considered distinct admissions, regardless of the number of days occurring between admissions.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

C. GENERAL REIMBURSEMENT POLICIES (cont.)

11. Administrative Days Policy

Administrative days are those days of hospital stay wherein an acute inpatient level of care is no longer necessary, and an appropriate non-inpatient hospital placement is not available. Administrative days are reimbursed at the statewide average Medicaid nursing home per diem rate.

For a DRG payment case, administrative days are not paid until the case exceeds the high-cost outlier threshold for that case. If the hospital admission is solely for a stay until an appropriate sub-acute placement can be made, the hospital may be reimbursed at the Administrative Day per diem rate from the date of admission. The administrative rate is adjusted November 1. For DRG exempt cases, administrative days are identified during the length of stay review process.

12. Inpatient vs. Outpatient Stay Policy

Through October 31, 2004, stays of less than, approximating, or exceeding 24 hours where an inpatient admission was not appropriate will be reimbursed on an outpatient basis. Stays of less than 24 hours involving the death of the patient, transfer to another acute care hospital, a delivery, or initial care of a newborn are considered inpatient and are reimbursed under the respective inpatient payment method designated for the hospital and/ or the covered services. On and after November 1, 2004, a new clinical-based inpatient vs. outpatient stay determination rule is in effect.

An inpatient stay is an admission to a hospital based on an evaluation of the client using objective clinical indicators for the purpose of providing medically necessary inpatient care, including assessment, monitoring, and therapeutic services as required to best manage the client's illness or injury, and that is documented in the client's medical record.

An outpatient hospital stay consists of outpatient hospital services that are within a hospital's licensure and provided to a client who is designated as an outpatient based on an evaluation of the client using objective clinical indicators for the purpose of providing medically necessary ambulatory care, including assessment, monitoring, and therapeutic services as required to best manage the client's illness or injury, and that is documented in the client's medical record.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

C. GENERAL REIMBURSEMENT POLICIES (cont.)

13. Medicare Related Policies

Medicare crossovers refer to hospital patients who are eligible for Medicare benefits and Medical Assistance. For clients, the state considers the Medicare DRG payment to be payment in full. The state will pay the Medicare deductible and co-insurance related to the inpatient hospital services. Total Medicare and Medicaid payments to a provider cannot exceed DSHS's rates or fee schedule as if they were paid solely by Medicaid using the RCC payment method.

In cases where the Medicare crossover client's Part A benefits, including lifetime reserve days, are exhausted, and the Medicaid outlier threshold status is reached, the state will pay for those allowed charges beyond the threshold using the outlier policy described in C.3. above.

14. Fixed Per Diem Rate

A fixed per diem rate is used to reimburse for the LTAC program. A fixed per diem is also used to pay for authorized inpatient pain center services.

These fixed per diem rates are established through identification of historical claims costs for the respective services provided. Predetermined Vendor rate adjustments are made annually if rates are not rebased. For SFY 04 the vendor rate adjustment is 0.0%.

15. Third-Party Liability Policy

For DRG cases involving third-party liability (TPL), a hospital will be reimbursed the lesser of the DRG billed amount minus the TPL payment and other appropriate deductible amounts, or the applicable DRG allowed amount (basic payment) for the case minus the TPL payment and other appropriate deductible amounts. For RCC cases involving TPL, a hospital will be reimbursed the RCC allowed amount (basic payment) minus the TPL payment and other appropriate deductible amounts. For CAH cases involving TPL, a hospital will be reimbursed the allowed amount (basic payment) minus the TPL payment and other appropriate deductible amounts. For "full cost" cases involving TPL, a hospital will be reimbursed the federal match portion of the allowed amount (basic payment) minus the TPL payment and other appropriate deductible amounts.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

C. GENERAL REIMBURSEMENT POLICIES (cont.)

16. Day Outliers:

Section 1923(a)(2)(C) of the Act, requires the state to provide payment adjustment for hospitals for medically necessary inpatient hospital services involving exceptionally long length of stay for individuals under the age of six in disproportionate share hospitals and any hospital for a child under age one.

A hospital is eligible for the day outlier payment if it meets the following:

a. Any hospital serving a child under age one or is a DSH hospital and patient age is 5 or under.

b. The patient payment is DRG.

c. The charge for the patient stay is under $33,000 (cost outlier threshold).

d. Patient length of stay is over the day outlier threshold for the applicable DRG.

The day outlier threshold is defined as the number of an average length of stay for a discharge (for an applicable DRG), plus twenty days.

The Day Outlier Payment is based on the number of days exceeding the day outlier threshold, multiplied by the administrative day rate. Day outliers will only be paid for cases that do not reach high cost outlier status. A patient's claim can be either a day outlier or a high cost outlier, but not both.

17. Trauma Care Enhancement

The Level I, II, and III trauma center enhanced payment is based on the trauma care fund established by the State of Washington in 1997 to improve the compensation to physicians and designated trauma facilities for care to Medicaid trauma patients. The payment is made through lump-sum supplemental payments made quarterly.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

C. GENERAL REIMBURSEMENT POLICIES (cont.)

17. Trauma Care Enhancement (cont.)

The payment each hospital receives is proportional to the percentage that the department pays in total to all Level I, II, and III trauma centers quarterly for fee-for-service trauma case claims. Each qualifying hospital's payment percentage is then applied to the department's total enhanced trauma supplemental funds available for the quarter to determine the hospital's proportional payment from the quarter's trauma supplemental. A fee-for-service case qualifies for trauma designation if care provided has an Injury Severity Score (ISS) of 13 or greater for adults, 9 or greater for pediatric patients (through age 14 only), and transferred trauma patients regardless of ISS.

Level IV and V trauma centers are given an enhanced payment outside of Medicaid by the State's Department of Health using only State funds.

18. Adjustment for New Newborn Screening Tests

A payment adjustment is made for new legislatively approved and funded newborn screening tests not paid through other rates.

D. DRG COST-BASED RATE METHOD

The DRG cost-based rate is a calculated hospital specific dollar amount that is multiplied by the applicable DRG weight to produce the DRG payment. The rate has three components (operating, capital and direct medical education). The rate is established on the basis of hospital's average cost for treating a Medicaid patient during a base period. This amount is adjusted for the hospital's case mix and updated for inflation.

1. Base Period Cost and Claims Data

The base period cost data for the rates are from hospitals' Medicare cost reports (Form CMS 2552) for their fiscal year (FY) 1998. Cost data that was desk reviewed and/or field audited by the Medicare intermediary before the end of the rebasing process was used in rate setting when available.

Three categories of costs (total costs, capital costs, and direct medical education costs) are extracted from the CMS 2552 for each of the 38 allowed categories of cost/revenue centers used to categorize Medicaid claims.